

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12569

12582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				d. STREET ADDRESS (Son) Route # 2, % Noah Bittinger		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nancy		First	Middle	Last	4. DATE OF DEATH November	Month	Doy	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-30-1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bittinger, Maryland		12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Burkholder				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (Son) Noah Bittinger, Route # 2, Swanton, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Pneumonia, terminal (5 days) b. Arteriosclerosis, 2. br. 11. 6 mos		INTERVAL BETWEEN ONSET AND DEATH 3 days			
		DUE TO							
		(c) Arteriosclerosis, 2. br. 11. 6 mos				Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sen. L. + 7									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Swanton		(County)	(State)
21. I certify that I attended the deceased from 11-20, 1958, to 11-22, 1958, that I last saw the deceased alive on 11-21, 1958, and that death occurred at 7:50 AM, from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster Jr., M. D.		ADDRESS (Street, city or town, state) 58 21 St. Oakland, Md. 11-22-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/24/1959		22c. NAME OF CEMETERY OR CREMATORIUM none Cemetery		22d. LOCATION (City, town, or county) Swanton, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE Charles S. Trahan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician and completely filled in by him. General director,
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12583

CERTIFICATE OF DEATH

Reg. Dist. No.

12570

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland.		b. COUNT Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland,		c. LENGTH OF STAY IN 1b 88 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Mi. N. Oakland				d. STREET ADDRESS /3 Mi. N. Oakland,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle P.	Last DeBerry	4. DATE OF DEATH November 12, 1959	Month November	Day 12	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1871		9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Clark DeBerry		14. MOTHER'S MAIDEN NAME Jane Fredlock						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT William F. DeBerry		Address Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1		DUE TO Cysto- sis, Iaure, Du		INTERVAL BETWEEN ONSET AND DEATH 276 days				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Auricular J. brilat.		2 yrs				
(c) Dystro- closis				7 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anterior (hypertrophic				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland, Md.	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Aug. 15, 1959</u> , that I last saw the deceased alive on <u>Aug. 15, 1959</u> , and that death occurred at <u>5821 St. Oakland, Md.</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster, M. D.						ADDRESS (Street, city or town, state) 5821 St. Oakland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/1959		22c. NAME OF CEMETERY OR CREMATORI DeBerry Family Cemetery near Oakland, Md.		22d. LOCATION (City, town, or county) (State) near Oakland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Keighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Cathleen S. Krause		

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12584 CERTIFICATE OF DEATH 12571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. LENGTH OF STAY IN 1b 4 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home of Ward Smith		d. STREET ADDRESS Home of Ward Smith	
3. NAME OF DECEASED (Type or print) Toliver Martin Denning		4. DATE OF DEATH November 4, 1959	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 6, 1883
8. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		9. AGE (In years 76 birthday) yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Preacher		10b. KIND OF BUSINESS OR INDUSTRY Baptist Church	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Peter Denning		14. MOTHER'S MAIDEN NAME Sarah Cauhorn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 168-22-1120	17. INFORMANT Mrs. Ward Smith Address R.D. Deer Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Congestive heart failure			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/16/58 , 19, to 11/4/59 , 19, that I last saw the deceased alive on 10/13/59 , 19, and that death occurred at 2:30A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 25aeder St. Oakland Md. DATE SIGNED 11/5/59	
ACTUAL SIGNATURE E. I. Baumgartner		PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/6/1959	22c. NAME OF CEMETERY OR CREMATORIUM Ferndale Cemetery	22d. LOCATION (City, town, or county) near Oakland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE NOV 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12585

CERTIFICATE OF DEATH

Reg. Dist. No.

12572

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYARD		d. STREET ADDRESS 5 Mi. S. Bayard			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BLANCHE		First E.	Middle FLUKE	Lost FLUKE	4. DATE OF DEATH NOVEMBER 17 1959	Month NOVEMBER	Day 17	Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1886	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR 73	IF UNDER 24 HRS. Months 73	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILDESEN, WILLIAM C.		14. MOTHER'S MAIDEN NAME THOMPSON, MARY C.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT ELWOOD FLUKE		Address BAYARD, W. VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		<i>Pneumonia, terminal</i>						2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Myocardial heart disease c		<i>Myocardial heart disease c</i>						3-4 mos	
(c) DUE TO Arthritis deformans		<i>Arthritis deformans</i>						25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-29 , 19 59 , to 11-17 , 19 59 , that I last saw the deceased alive on 11-17 , 19 59 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Oakland, Md.	
ACTUAL SIGNATURE <i>Andrew E. Mance</i>								DATE SIGNED 18 Nov 59	
PHYSICIAN'S NAME (Type) DR. ANDREW E. MANCE		OAKLAND, MARYLAND							
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/1959		22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery		22d. LOCATION (City, town, or county) near Gorman, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Koenig</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12573

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 DAY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SANG RUN RURAL				
3. NAME OF DECEASED (Type or print) FANNIE		First J.	Middle FRIEND			
4. DATE OF DEATH NOVEMBER 11 1959	Month NOVEMBER	Day 11	Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10, 1883			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John DeWitt				
14. MOTHER'S MAIDEN NAME Margaret Hawk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO. ---		17. INFORMANT MARY MARTHA FRIEND	Address Sang Run, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 3 days				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Bilateral Pneumonia. Generalized arteriosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Nov. 11, 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 25 Alder St	20f. (City or town) OAKLAND, MARYLAND	(County) OAKLAND	(State) MARYLAND
21. I certify that I attended the deceased from Nov. 11, 1949 to Nov. 11, 1959 that I last saw the deceased alive on Nov. 4, 1959 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) OAKLAND, MARYLAND				
ACTUAL SIGNATURE E. I. Baumgartner		DATE SIGNED 11/15/59				
PHYSICIAN'S NAME (Type) DR. E. I. BAUMGARTNER		OAKLAND, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/1959	22c. NAME OF CEMETERY OR CREMATORIUM Sang Run Cemetery	22d. LOCATION (City, town, or county) Sang Run, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR NOV 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12587

CERTIFICATE OF DEATH

Reg. Dist. No.

12574

1. PLACE OF DEATH a. COUNTY <i>GATTETT</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Garrett</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Freudsvele Md.</i>		c. LENGTH OF STAY IN 1b <i>all of life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Freudsvele Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas - Ray - FRIEND</i>		d. STREET ADDRESS <i>1 Sen Delivery</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas - Ray - FRIEND</i>		4. DATE OF DEATH <i>Nov. 27 1959</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 12-1902</i>		9. AGE (In years lost birthday) <i>57 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lumber Industry</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Timber</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		13. FATHER'S NAME <i>Thomas Friend</i>	
14. MOTHER'S MAIDEN NAME <i>Nettie Gibbs</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Thelma Friend - Freudsvele Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>451X</i> DUE TO <i>Circulatory Failure (Shock)</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Ruptured Abdominal Aortic Aneurysm</i> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Friendship, Md.</i> (County) <i>Freudsvele</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Oct. 1958</i> to <i>Nov. 1959</i> , that I last saw the deceased alive on <i>11-25-1959</i> , and that death occurred at <i>4:30 A.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>Friendship, Md.</i> DATE SIGNED <i>27 Nov 59</i>	
ACTUAL SIGNATURE <i>Pedro Rivera</i>		PHYSICIAN'S NAME (Type) <i>Pedro RIVERA</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 29 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Stiles Cemetery</i>
22d. LOCATION (City, town, or county) <i>Freudsvele</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.H. Rodakauer</i>		24a. ADDRESS <i>Markleyburg, Pa.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
VS A15 (4)		DATE DEC 1 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12575

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCIDENT, MD		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle ELIZABETH	Last GEORG
4. DATE OF DEATH	Month Nov.	Day 15	Year 1957
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 22, 1878
9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) ACCIDENT GARRETT CO. U.S.A.
13. FATHER'S NAME HENRY KOLB	14. MOTHER'S MAIDEN NAME LOUISE SPOERLING		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. ____	INFORMANT ____	Address Mr. George F. Georg, Accident, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure INTERVAL BETWEEN ONSET AND DEATH 3 years			
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease 10 years			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October, 1957 to Nov. 15 1957 that I last saw the deceased alive on Nov. 15, 1959 , and that death occurred at 8:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 11/17/59			
ACTUAL SIGNATURE Georgie Strong M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/18/59	22c. NAME OF CEMETERY OR CREMATORIAL ACCIDENT	22d. LOCATION (City, town, or county) ACCIDENT GARRETT CO., MD (State)
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Khan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12589

CERTIFICATE OF DEATH

12576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence at Sand Flat		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park	
3. NAME OF DECEASED (Type or print) First Thomas Middle Edward Last Harvey		d. STREET ADDRESS Residence at Sand Flat	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH May 25, 1873
8. AGE (In years from birthday) 86	9. IF UNDER 1 YEAR yrs. Months Days Hours Min.	10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past 5 years, if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen. Mdse. & Meat	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Harvey		14. MOTHER'S MAIDEN NAME Elizabeth Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-3327	
17. INFORMANT Mrs. Edward Harvey		Address R.D. Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Acute Myocardial Suffusion Cardio-Vascular and Disease INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic arteritis (Gout). Large Debulking biliary lip			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1950	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1950 to Nov. 10, 1959 that I last saw the deceased alive on Nov. 9, 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph Calandrella</i>		ADDRESS (Street, city or town, state) M.D. Kitzmiller, Md.	
PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.		DATE SIGNED Nov. 12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Deer Park, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leyton</i>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician and completely filled in by funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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VS A15 (4)
 15M 9/5B

090

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12577

12590 CERTIFICATE OF DEATH

Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN Tb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROWLESBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME		d. STREET ADDRESS BUFFALO STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES FRANK HIGH		First	Middle
		Last	
4. DATE OF DEATH NOVEMBER 13, 1959		Month	Day
		Year 19	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOSTLER		10b. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD CO	
11. BIRTHPLACE (State or foreign country) ROWLESBURG, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME HENRY HIGH		14. MOTHER'S MAIDEN NAME ELIZABETH PETERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT HENRY R. HIGH, CHARLESTON, W. VA.	
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) , ,	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 11</u> , 1959, to <u>Nov 13</u> , 1959, that I last saw the deceased alive on <u>Nov 11</u> , 1959, and that death occurred at <u>M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>William Harriman</u> M.D. ADDRESS (Street, city or town, state) <u>Terra Alta, W. Va.</u> DATE SIGNED <u>12/1/59</u>			
PHYSICIAN'S NAME (Type) WILLIAM HARRIMAN, M. D.		TERRA ALTA, WEST VIRGINIA	
22a. BURIAL, CREMATION BURIAL (Specify)		22b. DATE THEREOF NOVEMBER 16, 1959, AURORA CEMETERY	
22c. NAME OF CEMETERY OR CREMATORIAL AURORA, WEST VIRGINIA		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belleson</u>		24a. ADDRESS TERRA ALTA, W. VA.	24b. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur & Krause</u>	
F.D. Md. No. A 7220			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12591

CERTIFICATE OF DEATH

Reg. Dist. No.

12578

1. PLACE OF DEATH a. COUNTY GARRETT		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 15 hr., 45 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 9 OAK ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle	Last	4. DATE OF DEATH Month NOVEMBER	Day 6	Year 1959				
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH SEPTEMBER 4, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES		14. MOTHER'S MAIDEN NAME KERINS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-3427		17. INFORMANT MARCELLA KERINS, 9 OAK ST, OAKLAND MD.		Address MELVIN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Lungema, Auto., Leuophatic Arterosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 Weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAKLAND		20f. (City or town) OAKLAND		(County) OAKLAND		(State) MARYLAND	
21. I certify that I attended the deceased from Jan. 19 , 1956, to Jan. 6 , 1959, that I last saw the deceased alive on Jan. 6 , 1959, and that death occurred at 6:10 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) OAKLAND, MD.						DATE SIGNED 7 Mar 59	
ACTUAL SIGNATURE Andrea F. Mance											
PHYSICIAN'S NAME (Type) ANDREA F. MANCE, M.D.											
22a. BURIAL, CREMATION, BURIAL <input type="checkbox"/> (Specify)		22b. DATE THEREOF 11/9/1958		22c. NAME OF CEMETERY OR CREMATORIAL Catholic Cemetery		22d. LOCATION (City, town, or county) OAKLAND, MD.					
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leydon		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '59		24b. REGISTRAR'S SIGNATURE Julius S. Kraus					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12579

12592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				d. STREET ADDRESS Star Route		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Francis		First	Middle	Last	4. DATE OF DEATH November	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/9/1886	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Pa/ Elec. Co.		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME James B. Kershner				14. MOTHER'S MAIDEN NAME Julia M. Martin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-2261		17. INFORMANT Virginia Kershner (sister)		Address McHenry, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbinal</i> DUE TO <i>Vascular Accident</i> INTERVAL BETWEEN 331X Conditions, if any, which <i>1dy extension</i> ONSET AND DEATH gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Y years</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Nov</i> , 19 <i>59</i> , to <i>11-25</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>November 25</i> , 19 <i>59</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. Feaster, Jr.</i> ADDRESS (Street, city or town, state) <i>58 2-1 St. Oakland, Md.</i> DATE SIGNED <i>11-25-59</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/1959		22c. NAME OF CEMETERY OR CREMATORIUM Red House Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

Reg. Dist. No.

12580

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGHENY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALNUT		d. STREET ADDRESS Westernport		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS Hammond St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Antonette		First	Middle	Last	4. DATE OF DEATH LEASE	Month NOVEMBER	Day 23	Year 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 13, 1884		9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY ownhome		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME JAMES ALLEGRETTO				14. MOTHER'S MAIDEN NAME ANTONINETTE MAULE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. BESS CUPPETT		Address OAKLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Congestive Heart failure Cardiovascular accident Generalized Arteritis sclerous								
INTERVAL BETWEEN ONSET AND DEATH 1wk								
3 hrs								
?								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture left forearm. Diabetes mellitus								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from July 1957 to Nov. 1959, that I last saw the deceased alive on Nov. 23, 1959, and that death occurred at 7:00 P.M., from the causes and on the date stated above.								
ACTUAL SIGNATURE S. J. Baumgartner							ADDRESS (Street, city or town, state) M.D. 25 Alder St	DATE SIGNED 11/23/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Peters Cemetery		22d. LOCATION (City, town, or county) Westernport Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. F. Fulkerson		ADDRESS Piedmont, W. Va.		24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE C. S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - DIVISION OF STATE CHAIRMEN

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12581

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Oakland		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point Pleasant		d. STREET ADDRESS 85 x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) George		First Alfred	Middle Nightingale	Lost	4. DATE OF DEATH 11	Month 25	Day Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1899		9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Alfred Nightingale		14. MOTHER'S MAIDEN NAME Mary Lyons		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Nightengale, Lonaconing, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lonaconing	(County) W. Va.	(State) W. Va.
21. I certify that I attended the deceased from <u>June 18</u> , 1959, to <u>Dec. 25</u> , 1959, that I last saw the deceased alive on <u>Nov. 12</u> , 1959, and that death occurred at <u>85 Alder St</u> , Lonaconing, MD, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 85 ALDER ST LONACONING, MD								
ACTUAL SIGNATURE <u>J. Eichhorn</u>	PHYSICIAN'S NAME (Type) <u>George Eichhorn</u>	M.D.	DATE SIGNED 11/27/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 11/28/1959	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing, MD. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn			ADDRESS Lonaconing, MD.	24a. REC'D BY REGISTRAR DATE DEC 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

NAME

DEATH DATE

CERTIFICATE OF DEATH

ILLINOIS DEPARTMENT OF PUBLIC SAFETY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12582

12595

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural SWANTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 4 Mi. N. Swanton	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First STEWART Middle A. PAUGH		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MAR. 11 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done. If kind of business or industry during most of working life, even if retired) RETIRED OWN FARM FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY PAUGH		14. MOTHER'S MAIDEN NAME ELLEN TICHNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT CLARENCE PAUGH		Address SWANTON, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 10, 1959, to NOV. 12, 1959, that I last saw the deceased alive on NOV. 12, 1959, and that death occurred at 1:20 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Andrew E. Mance</i> ADDRESS (Street, city or town, state) <i>Oakland, Md.</i> DATE SIGNED <i>12 Nov 59</i>			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		3rd STREET OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, 22b. DATE THEREOF Burial 11/15/1959		22c. NAME OF CEMETERY OR CREMATORIUM North Glade Cemetery	
22d. LOCATION (City, town, or county) near Swanton, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>He. Reighton</i>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE <i>Curious & True</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ARKANSAS - DEPARTMENT OF HEALTH - STATE OF ARKANSAS

DEPARTMENT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12583

Reg. Dist. No.

12595

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If no & no corporate limits, write RURAL and give nearest town) Gorman		c. LENGTH OF STAY IN lb 4 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE <input checked="" type="checkbox"/> Maryland COUNTY <input checked="" type="checkbox"/> Garrett			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Mi. West Gorman, Md. on Farm		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman, W. Va. Post Office		d. STREET ADDRESS 3 Mi. West Gorman, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle William	Last Pope	4. DATE OF DEATH Nov. 14, 1924	Month November	Day 7	Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 14, 1924	9. AGE (In years from birthday) 35 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer		10b. KIND OF BUSINESS OR INDUSTRY for others		11. BIRTHPLACE (State or foreign country) Maryland.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Pope		14. MOTHER'S MAIDEN NAME Dorothy Liller							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> yes		16. SOCIAL SECURITY NO. 17. INFORMANT 2nd W.W. 215-36-9957 Mrs. Virginia Pope		Address Gorman, W. Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration; Starvation		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 wks.			
309X Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last.		(b) Self inflicted fasting		DUE TO				2 wks.	
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James H. Feaster Jr. M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-8-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/1959	22c. NAME OF CEMETERY OR CREMATORIUM Pope Cemetery	22d. LOCATION (City, town, or county) near Gorman, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE Charles S. Krause				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MICHIGAN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED PERSON'S NAME: JOHN D. BROWN

DECEASED PERSON'S ADDRESS: 12345 BROWN ST. BROWN CITY, MI 49012

DECEASED PERSON'S AGE: 55

DECEASED PERSON'S GENDER: MALE

DECEASED PERSON'S RACE: WHITE

DECEASED PERSON'S HEIGHT: 5'10"

DECEASED PERSON'S WEIGHT: 180 LBS

DECEASED PERSON'S HAIR COLOR: BLACK

DECEASED PERSON'S EYE COLOR: BROWN

DECEASED PERSON'S BIRTH DATE: 01/01/1940

DECEASED PERSON'S DEATH DATE: 01/01/1995

DECEASED PERSON'S DEATH TIME: 11:59 PM

DECEASED PERSON'S DEATH PLACE: HOME

DECEASED PERSON'S DEATH CAUSE: HEART DISEASE

DECEASED PERSON'S DEATH PLACE: HOME

DECEASED PERSON'S DEATH CAUSE: HEART DISEASE

DECEASED PERSON'S DEATH PLACE: HOME

DECEASED PERSON'S DEATH CAUSE: HEART DISEASE

DECEASED PERSON'S DEATH PLACE: HOME

DECEASED PERSON'S DEATH CAUSE: HEART DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12597

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12584

1. PLACE OF DEATH a. COUNTY Garrett			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital			d. STREET ADDRESS Route # 2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Theodore			First	Middle	Last	4. DATE OF DEATH November 29	Month	Day	Year	1959			
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1908	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timberman & Farmer			10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Sang Run, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Simon Reckart			14. MOTHER'S MAIDEN NAME Nora Sines			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-28-9713		17. INFORMANT (Wife) Delia Uphold Reckart	Address Route # 2 Deer Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>January</u> , 19 <u>53</u> , to <u>November 29, 1959</u> , that I last saw the deceased alive on <u>Nov. 28, 1959</u> , and that death occurred at <u>12:11 AM</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 2540 E. BOSTON ST			DATE SIGNED 11/29/59				
ACTUAL SIGNATURE <u>E. I. Baumgartner</u>			PHYSICIAN'S NAME (Type) <u>E. I. Baumgartner</u>			22. BURIAL, CREMATION, BURIAL (City) 12/2/1959			22c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose Cemetery		22d. LOCATION (City, town, or county) near Friendsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u>			ADDRESS Oakland, Md.			24a. REC'D. BY REGISTRAR DEC 1 1959		24b. REGISTRAR'S SIGNATURE <u>John S. Hayes</u>					

81. BROMMEL-HAAR-DAHLIA-CHART

CERTIFICATE OF DEATH

18

Death in 1968

877-52-05

02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12598 CERTIFICATE OF DEATH

Reg. Dist. No. 12585

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND GARRETT b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND 2 days		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GRANTSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE # 2	
3. NAME OF DECEASED (Type or print) ROSA First MAE Middle ROSS Last		4. DATE OF DEATH NOVEMBER 11 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MAY 18, 1883	9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or Foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS LAYMAN		14. MOTHER'S MAIDEN NAME ELIZABETH KNEPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT CHARLES W. ROSS ROUTE # 2 -GRANTSVILLE, Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardiac Infarction</i> INTERVAL BETWEEN ONSET AND DEATH MD. 4 days 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Anteroseptenitis - Generalized</i> 4 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia - B. lateral</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-9 , 19 59 , to 11-11 , 19 59 , that I last saw the deceased alive on 11-11 , 19 59 , and that death occurred at 10:45A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		ADDRESS (Street, city or town, state) 58 2nd st. Oakland - d DATE SIGNED 11-11-59	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.		2nd STREET OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/13/59 22c. NAME OF CEMETERY OR CREMATORIAL NEW GERMANY REFORMED CHURCH 22d. LOCATION (City, town, or county) GARRETT Co. MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman, Grantsville, Md</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 16 '59	
		24b. REGISTRAR'S SIGNATURE <i>Charles & Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12599

CERTIFICATE OF DEATH

Reg. Dist. No.

12586

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penns.		b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN lb 10 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Oak Borough		75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Weeks Nursing Home				d. STREET ADDRESS 1605 California Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel		First	Middle Reed	Lost Shillite	4. DATE OF DEATH November 27, 1959	Month November	Day 27	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1877		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Field Worker		10b. KIND OF BUSINESS OR INDUSTRY maintenance		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William G. Shillite				14. MOTHER'S MAIDEN NAME Rebecca H. Provines					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 167-07-8721A		17. INFORMANT James R. Shillite, White Oak Borough,		Address Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation and Malnutrition DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinomatosis DUE TO (c) Primary in Bowel INTERVAL BETWEEN ONSET AND DEATH 8 weeks 6 mos 1 yr.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 2nd st. Oakland, Md.	20f. (City or town) 58 2nd st. Oakland, Md.	(County) Burgettstown, Penna.	(State) Burgettstown, Penna.
21. I certify that I attended the deceased from April 1, 1959, to 11-25, 1959, that I last saw the deceased alive on 11-25, 1959, and that death occurred at 9:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd st. Oakland, Md. DATE SIGNED 11-28-59									
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.									
PHYSICIAN'S NAME (Type)		James H. Feaster, Jr., M. D. Oakland, Md.							
Burial or CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/30/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) Burgettstown, Penna. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighston		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Price			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12600

CERTIFICATE OF DEATH

12587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OAKLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 1/ 25 THIRD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BABY		First	Middle	Last	4. DATE OF DEATH NOVEMBER	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 2, 1959	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME SWARTZENTRUBER, DELBERT DONALD		14. MOTHER'S MAIDEN NAME GLOVER, DORIS ELIA						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. DORIS SWARTZENTRUBER		Address 25 THIRD ST. OAKLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day				
Intracranial trauma		1 day						
Labor-Premature (Excessive Caput)		1 day						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <u>Nov 2</u> , 1959, to <u>Nov 3</u> , 1959, that I last saw the deceased alive on <u>Nov 3</u> , 1959, and that death occurred at <u>10:00P</u> M, from the causes and on the date stated above.						ADDRESS (Street, city or town state) M.D. 77 Oak St., Oakland, Md. 44059		DATE SIGNED
ACTUAL SIGNATURE Herbert H. Leighton								
PHYSICIAN'S NAME (Type) DR. HERBERT H. LEIGHTON				OAKLAND, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/4/1959		22c. NAME OF CEMETERY OR CREMATORIUM Gortner Cemetery		22d. LOCATION (City, town, or county) Gortner, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. DOMITIAR-HIGH TO THE HIGHEST STATE QUALITY

STATE TO STATE

ST. DOMITIAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12601

CERTIFICATE OF DEATH

Reg. Dist. No.

12588

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland.		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 75 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		d. STREET ADDRESS 104 Center St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Center St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Margaret	Middle Irene	Last Treacy	4. DATE OF DEATH November 14, 1959	Month November	Day 14	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1880	9. AGE (In years less birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James P. Treacy		14. MOTHER'S MAIDEN NAME Mary Boyle							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO. 218-30-0751		17. INFORMANT Mrs. A. G. Hesen		Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3m					
(b) DUE TO Generalized Arteriosclerosis									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Branch</u> , 1949, to <u>Nov</u> , 1959, that I last saw the deceased alive on <u>October 15</u> , 1959, and that death occurred at <u>8:20P</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <u>E. I. Baumgartner</u>				DATE SIGNED 11/16/59					
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.		Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/1959	22c. NAME OF CEMETERY OR CREMATORIUM Catholic Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR NOV 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

BY PROMULGATION TO THE STATE OF CALIFORNIA

BY ACT OF THE STATE LEGISLATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602

CERTIFICATE OF DEATH

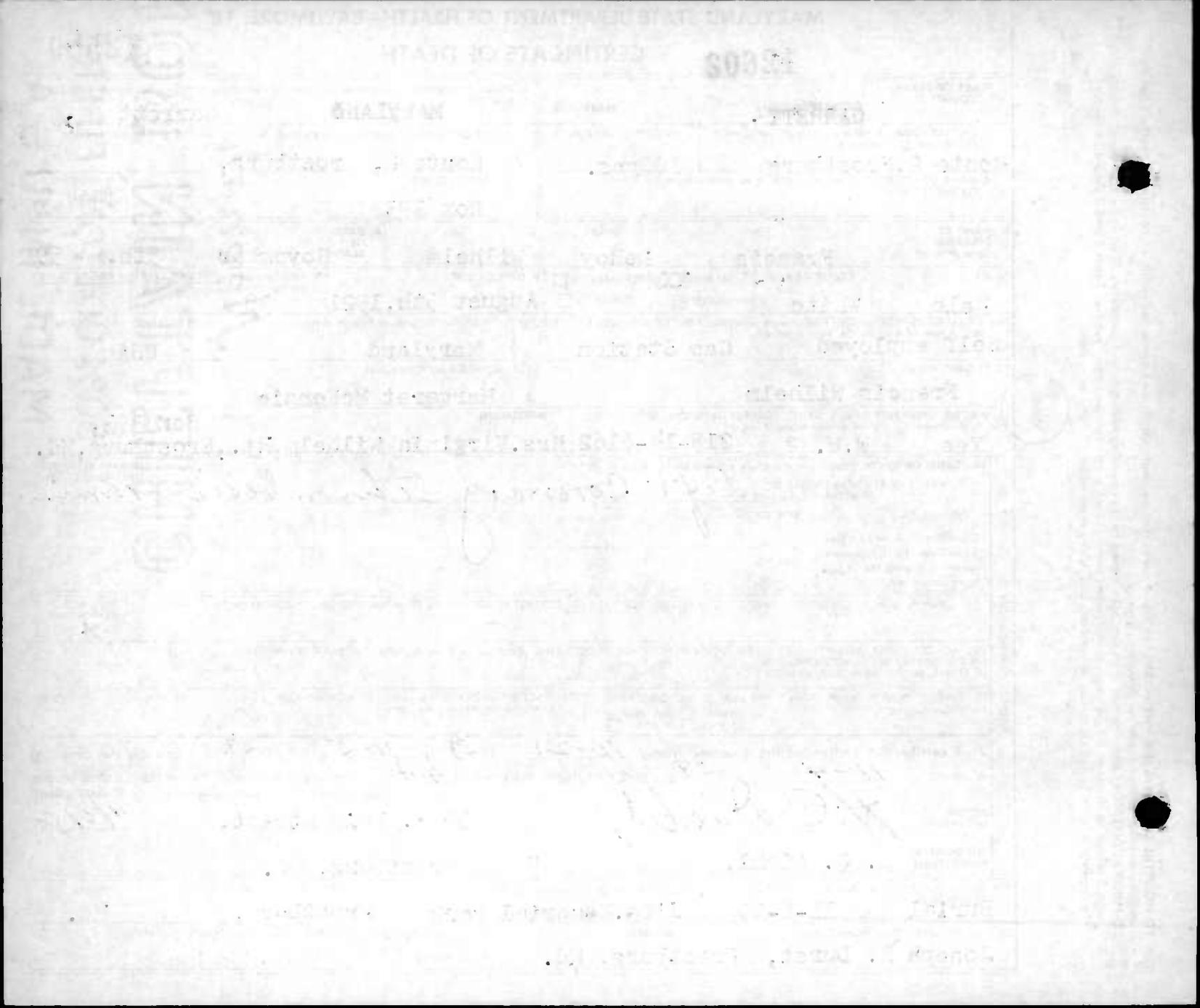
Reg. Dist. No.

12589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
GARRETT MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Frostburg,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Box 393	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Francis		LeRoy	Wilhelm
4. DATE OF DEATH		Month	Day
November		5th,	19 59
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
August 5th, 1921		38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Wilhelm		14. MOTHER'S MAIDEN NAME Margaret McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 215-14-6162	
17. INFORMANT Mrs. Virginia Wilhelm, Rt., Frostburg, Md.		Address Box 393,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Left Coronary Thrombosis 15 min.	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE H. C. Diehl		ADDRESS (Street, city or town, state) 39 W. Main Street, Frostburg, Md. DATE SIGNED 11/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-59	
22c. NAME OF CEMETERY OR CREMATORIAL F' bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE NOV 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Haas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12603

CERTIFICATE OF DEATH

Reg. Dist. No.

12590

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kitzmiller Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS 4 Mi. West - Short Run		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elvin		First Milo	Middle Wilson	4. DATE OF DEATH November	Month 6	Day 1959	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1876	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Short Run, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Wilson		14. MOTHER'S MAIDEN NAME Mary Margaret Harvey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-9957		17. INFORMANT Mr. Thomas Wilson, Kitzmiller, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 9 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1959, to November 6, 1959, that I last saw the deceased alive on November 6, 1959, and that death occurred at 9:22 A. M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. E. Mance</i> M.D. ADDRESS (Street, city or town, state) <i>Oakland</i> DATE SIGNED <i>Nov 9 1959</i>							
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		Oakland, Maryland					
22a. BURIAL, CREMATION, Burying (Specify) Burial		22b. DATE THEREOF 11/9/1959		22c. NAME OF CEMETERY OR CREMATORIUM Short Run Cemetery		22d. LOCATION (City, town, or county) near Kitzmiller, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12591

12604 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY		G arrett	STATE		Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Kitzmiller		LENGTH OF STAY (in this place)	TOWN Kitzmiller		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		75 yrs.	STREET ADDRESS		(If rural give location)
Main Street			Main Street		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
Robert Jesse Wilson			Nov. 5, 1959		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Deyrs Hours Min.
Male	White	Married	June 26, 1870	89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Miner)			10b. KIND OF BUSINESS OR INDUSTRY		
			Coal Miner		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Baltimore, Md.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert Charles Wilson			Sarah Webb		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
No			None		
17. INFORMANT & ADDRESS			18. MEDICAL CERTIFICATION		
			Andrew Wilson, Kitzmiller, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
442x IMMEDIATE CAUSE (A) <i>Acute Myocardial Infarct</i>			3 days		
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardio + Vascular Compl/ Disease</i>			3 yrs.		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		
			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan. 1956</i> to <i>Nov. 5, 1959</i> , that I last saw the deceased alive on <i>Nov. 5, 1959</i> , and that death occurred at <i>6:20 A.M.</i> from the causes and on the date stated above.			ADDRESS (Street, city, town, state) DATE SIGNED <i>Kitzmillr, Md. Nov. 6-59</i>		
SIGNATURE <i>Ralph Colandella</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 11/8/59		
			NAME OF CEMETERY OR CREMATORIUM Hamill Cemetery		
24. REC'D BY REGISTRAR DATE NOV 10 '59			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>He. Leightlon Oakland, Md.</i>		

